WPHP Report: Physician Health Programs and the Equivalence Problem

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Over the last several years, many new players have entered the physician health and well-being space, offering an array of mental health, wellness, coaching, and other services aimed at health professionals who have been worn down by systemic drivers of burnout and a relentless global pandemic. While I am hopeful that these additional resources will be utilized and beneficial for our colleagues in distress, I am also concerned by the emergence of something I call the "equivalence problem." The equivalence problem is born of a mistaken belief that other organizations or individuals that assist (or want to assist) health professionals might be used as an alternative to physician health programs (PHPs).

At the June 2021 meeting of the American Medical Association (AMA) a report from Council on Judicial Affairs (CEJA) was passed that revised the AMA Code of Medical Ethics Opinion 9.3.2 to remove reference to utilization of PHPs for those impacted by risk of impairment. At the November 2021 meeting of the AMA House of Delegates (HOD) delegations from Pennsylvania, New York, and Wisconsin introduced Resolution 23 in an effort, among other things, to restore the reference to PHPs in 9.3.2.

Resolution 23 passed by a very wide margin reflecting widespread support at the AMA for returning the reference to PHPs in 9.3.2. However, in lead up to the vote, reference committee testimony from a member of CEJA revealed that some among AMA's ranks believe that there are many resources to support physician well-being and that PHPs should not enjoy the privilege of special recognition in 9.3.2. The unfolding of these events reinforced concerns about the equivalence problem that had been gnawing at me for some time.

Recent revisions to the American Society of Addiction Medicine (ASAM) and the Federation of State Medic al Boards (FSMB) policies relating to physician health were strongly supportive of PHPs and the PHP model. However, these policies also contain statements acknowledging that physicians and other health professionals may seek care from "other clinicians with expertise" without oversight of the PHP. On the surface, this is not surprising or particularly problematic. We all want health professionals to get care when needed and PHPs certainly do not want or need to be involved with all physicians who are ill. That said, such language edges toward the equivalence problem.

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In a recent update to the AMA Advocacy Resource Center (ARC) Issue Brief: confidential care to support physician health and wellness. the Federation of State Physician Health Programs had an opportunity to define the characteristics of PHPs which set them apart from other resources available to healthcare professionals, such as medical association Physician Wellness Programs, private monitoring agencies, or treatment providers with expertise in caring for physicians. I think it is worthwhile to expand further on the factors which are unique to PHPs here:

1. Legal authority: As is the case in Washington, a PHP may be the only legally authorized entity that may receive reports of impairment or potential impairment in lieu of a report to the disciplinary authority.
2. Special accountability: Through statute, rule, or contract with the disciplinary authority, PHPs have special accountability and mandatory reporting obligations designed to protect the public. Non-PHP providers may also have mandatory reporting obligations but, in my experience, most clinicians who care for physicians and physician assistants are unfamiliar with their reporting obligations and consequences for failure to report are often lacking.
3. Trusted verification: PHPs are trusted by employers, credentialing entities, licensing boards, medical specialty boards, and others to provide objective and ongoing verification that a health professional is safe to practice. PHP program compliance is often a requirement of continued employment, medical staff privileges, or licensure. Non-PHP providers are often unwilling to provide opinions regarding safety to practice or unable to meet the reporting needs of the involved entity. Such entities may also be reluctant to act in reliance upon information received from non-PHP provider who is ethically bound to act in the interest of their patient and may not fully appreciate the entity's responsibilities to address patient safety risks.
4. No treatment or other role conflict: PHPs do not provide treatment to participants and, therefore, do not have a treatment relationship that could create a conflict of interest with their obligation to act in the interest of public safety. PHPs seek to balance the rehabilitative needs of the participant with protection of the public. Non-PHP providers have a primary obligation to the interest of their patient which may help health professionals feel more comfortable disclosing worsening symptoms or very private information but may also create reluctance to report an impaired health professional. PHPs offer another layer of confidentiality protection when treatment providers working with health professionals are faced with the dilemma of preserving therapeutic trust and protecting the public.
5. Care management: PHPs provide oversight, communication, and coordination of health care to promote effective and sustained remission of chronic illnesses. PHPs also receive functional information from employers and key supports which, along with other monitoring data such as toxicology testing, can optimize the care a participant receives from their treatment providers. Outside of PHPs, this level of care management is virtually unavailable to health professionals.

These five characteristics differentiate PHPs from the growing list of services to support physicians in need of assistance. Clinicians and wellness professionals who treat physicians outside of the purview of a PHP should:

1. Thoughtfully appraise their ability to provide assurance of safety to practice for professionals in their care and understand the legal and ethical requirements for protecting public safety within the context of the therapeutic relationship.
2. Understand the circumstances in which involvement with a PHP might offer a benefit such as need for advocacy in employment, credentialing, or licensing matters.
3. Utilize the added layer of confidentiality protection that PHPs offer when a reportable concern for impairment arises.
4. Familiarize themselves with their state PHP and consult (anonymously if needed) if concerns of impairment arise. Proactive collaboration and relationship building with the PHP can help facilitate an excellent outcome when one is faced with a health professional in difficulty.

WPHP supports and encourages physicians and other health professionals to proactively address health-related problems and obtain needed treatment. We hope that early intervention will prevent progression of illness and need for PHP involvement. We believe that there is "no wrong door" for a clinician in trouble and that there are many effective, non-PHP options available. However, we also know that to equate expert clinicians, wellness programs, and PHPs diminishes the unique value that each bring in their service to the profession. Communication, collaboration, and role clarity among all involved can help ensure that health professionals in need with get the right care, for the right reasons, at the right time.